Initial findings from analysis of data from Child Death Review (CDR) processes in Australia and New Zealand

THE UNIVERSITY OF EDINBURGH / NSPCC
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SHORT PAPER

Initial findings from analysis of data from Child Death Review (CDR) processes in Australia and New Zealand

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This paper presents initial findings from phase one of an international study which aimed to pool knowledge and identify good practice across countries which review all child deaths, or all unexpected deaths, in order to inform learning around prevention. It is based on analysis of documentary data and data from in-depth individual and joint interviews with 41 key informants in Australia (12 in New South Wales, 15 in Queensland, 9 in Victoria, 4 in Western Australia and 2 in South Australia) and 17 in New Zealand.

KEY POINTS

- New Zealand has a nationally co-ordinated CDR process; there is no national co-ordination in Australia with states and territories all organising their systems differently
- New Zealand has extensive, good quality data on all deaths of children and young people up to 25; reliable national data is not available in Australia
- Some states in Australia have undertaken useful thematic analyses of CDR data and the findings of these analyses have been used to inform national policy and prevention initiatives and facilitate practice improvement
- Some CDR teams in Australia and New Zealand lack powers to monitor whether their recommendations are being implemented; South Australia has strong legislation that enables this
- CDR teams in Australia and New Zealand struggle to demonstrate that their work contributes to reducing numbers of child deaths but CDR has nevertheless contributed to the development of effective policies and practice initiatives to better protect children and young people.

BACKGROUND

Research suggests that significant proportions of child deaths may be preventable[i]. Mechanisms for reviewing child deaths vary within and across countries. Some areas review only deaths from abuse and neglect; others take a wider public health approach, involving review of all deaths. There is a growing body of evidence on the effectiveness of comprehensive CDR processes – they have contributed significantly to knowledge about child abuse and neglect and have led to policies and initiatives that have made a major contribution to keeping children safe[ii]. There is much that the UK can learn from initiatives in other countries including Australia and New Zealand.

OVERVIEW OF CDR PROCESSES IN AUSTRALIA AND NEW ZEALAND

Six of the eight states and territories in Australia have some sort of CDR team or committee but there is considerable variation in the way that CDR is organised across Australia. Review is undertaken at state/territory level in Australia; there are no local review systems. The different systems are underpinned by very different legislative and operational frameworks which vary considerably in terms of level of independence and scope of review.

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Some states prioritise deaths of children known to the child protection system. It is common for Australian states to have a two tier system whereby one body undertakes reviews and another provides an oversight role.

In contrast to Australia where CDR is fragmented across different states and territories New Zealand has a national, co-ordinated, single tier system of review. Its model of local review, organised at health board level, drew heavily on the system of review developed in the United States. The substantial role of the Ministry of Health in developing, implementing and financing CDR has ensured, however, that New Zealand's system is a more centrally co-ordinated system than that in the United States. The Child and Youth Mortality Review Committee (CYMRC) is required to review and report on the deaths of all children and youth in New Zealand (aged 28 days to 24) with a view to reducing these deaths and to continuous quality improvements.

NATIONAL DATA

Because there is no standardised process of review across Australia it is not possible to obtain reliable national data about child deaths there. In contrast New Zealand has spent many years constructing an excellent data system to support its child mortality review process. It has a single, centralised, secure access database of all child deaths and deaths of young people up to and including age 24. The database is based on the National Centre for Child Death Review case reporting system which is used by many states in the US but unlike in the US where national comparison is problematic, the Ministry of Health provide dedicated resources to every District Health Board (DHB) to ensure data is entered in the same way across New Zealand.

Local groups may do things a little differently but the system is probably as co-ordinated as it is possible to be. The database is held at the University of Otago where the New Zealand Mortality Review Data Group are contracted to manage child mortality data.

THEMATIC ANALYSIS

Collating the data from individual reviews at a state or national level and undertaking regular analyses of this data enables a large data base of information to be built up. Once data has been collected for a number of years it can be used to identify particular trends or issues that may require further investigation and analysis. In New Zealand the national CYMRC report that after seven years of data collection they now have enough data to be able to drill into different types of deaths, and to look at specific issues in more detail using cross-case analysis. They were unable to do this in their first few years of operation because they were conscious of the dangers of working with small numbers.

A number of Australian states annually review their CDR data and use the findings from this analysis to identify particular issues or themes to investigate in-depth using themed group analysis. These group analyses are not just research exercises, they are often undertaken in collaboration with professionals and their aim is to facilitate practice learning. This approach to learning has a robust evidence base because the findings from a large group of cases are used to inform practice and policy rather than the findings from a single case.

Themed analyses have been undertaken on a number of issues in Australia including deaths from methadone ingestion, deaths from neglect, deaths related to co-sleeping, deaths from suicide, deaths of Aboriginal children and deaths where domestic violence was a factor.

In Victoria the findings from one group analysis were used to develop effective responses to chronic neglect and the learning from the analysis directly informed policy and practice. The project was undertaken during a time of legislative and policy reform within Victoria's child protection and family support system and was, therefore, timely in terms of being able to influence this reform. The impact of cumulative harm was recognised in a new policy and legislative framework in Victoria. The Children, Youth and Families Act 2005 and accompanying practice guidance and tools for staff[iii] gave greater attention to the cumulative effects of neglect and abuse on children's longer tem well-being and development and represented a shift away from an episodic focus on immediate harm.

New South Wales used a cohort project approach to increase staff awareness of the dangers of co-sleeping when parents used substances. Its aim was to increase their confidence and skills so they would be able to positively tackle the issue with parents and provide them with clear advice about the risks. Ultimately it was hoped that practice improvement in this area would result in a reduction in the numbers of child deaths where co-sleeping and substance misuse co-existed but that did not happen. A main finding of the cohort project was that staff were not confident in challenging parents. A number

of resources were developed: fact sheets were designed for staff outlining the findings from CDR and providing clear information about the risks; other resources - posters, brochures, wallet size information and fridge magnets were designed for staff to use to raise the issues with parents[iv]. The parental resources provide clear advice about the dangers of co-sleeping, outlining safe and unsafe practice and can easily be understood by people with low levels of literacy; aboriginal specific resources were also developed. In terms of reasons why parents shared sleeping surfaces with their babies, the study found that poverty, overcrowding and transience were major factors, particularly amongst the Aboriginal population. In order to tackle these issues resources were made available so that staff could provide families with money to purchase portable and non-portable cots and safe bedding.

DEMONSTRATING IMPACT

One of the strengths of CDR teams is that unlike coroners they can look across multiple cases and follow up on recommendations. Legislative mandates may require teams to report on findings and make recommendations to policy makers. Most Australian states have such legislation as do New Zealand but CDR teams also need to obtain feedback about what happens to their recommendations to find out whether they have been successfully implemented and whether they are actually making a difference.

South Australia's legislation is particularly useful in this respect because it stipulates that the CDR team must monitor the implementation of their recommendations. Some CDR teams in other states of Australia and in New Zealand do not have the resources to follow up on the recommendations they make and need to give recommendations to others to take forward and implement.

Accountability is an important issue. Newton and Frederick et al (2010)[v] have recommended that agencies in Australia be legally required to act on the recommendations of a review in order to increase accountability. Even if CDR teams can ensure that recommendations are implemented and reported on it is still very difficult to evaluate outcomes, demonstrate effectiveness and prove that their work actually makes a difference to children. One of the best measures of effectiveness is the extent to which CDR succeeds in reducing the number of child deaths but CDR teams often struggle to demonstrate this.

CONCLUSION AND IMPLICATIONS FOR THE UK

What New Zealand and some states in Australia do particularly well is they collect good quality national or state data, sometimes injury data as well as death data, which they analyse on a regular basis to identify important state or national trends. They then use this information to undertake in-depth analysis of particular themes and issues to help inform prevention initiatives and bring about policy and practice change to better protect children. Problems with the quality of national data in the UK have limited the extent to which we have been able to do this nationally. There is much we can learn from the way this is done in some Australian states and particularly in New Zealand where dedicated resources are allocated to DHBs and a University is commissioned to undertake national analysis to inform national policies and practice change.

While it is difficult to effectively demonstrate that CDR prevents children dying CDR in Australia and New Zealand, it has undoubtedly contributed to knowledge about abuse and neglect and led to policies and initiatives that have made major contributions to keeping children safe. There is much that the UK can learn from prevention initiatives in these countries.

ABOUT THE PROJECT

In 2010 I was awarded a Leverhulme Research Fellowship to enable me to conduct an international comparative study of CDR processes. The study considered what data is collected on child deaths in the UK, Australia, New Zealand and North America, what the data tells us about the main risk factors, how child deaths are reviewed, whether the different approaches to CDR in these countries are congruent with a public health approach and whether review has been effective in reducing child deaths.

A case study approach was adopted. The case studies comprised analysis of relevant documents such as international, national and local child homicide and fatality statistics and annual reports of CDR teams; they also included semi-structured interviews with key informants including policy makers, members of CDR teams, academics, and practitioners.

The study was undertaken in three distinct phases. The Leverhulme fellowship provided funding for Phase 1 which comprised fieldwork and analysis in Australia and New Zealand and phase 2 which comprised fieldwork and analysis in the United States and Canada. These two phases have been completed. Phase 3 which comprises fieldwork and analysis in the UK has yet to be undertaken.

Further information about this study can be obtained from sharon.vincent@wlv.ac.uk.

ABOUT THE CENTRE

The **Child Protection Research Centre** was set up in 2007 as a unique collaboration between The University of Edinburgh and the NSPCC. Our research is designed to generate a more integrated and deeper understanding of child protection in the UK and internationally, in order to strengthen policy and practice. Within this context we conduct two kinds of research:

- Critical comparison and analysis of child protection developments in legislation, policy and systems
- Primary research in areas of identified priority or gaps.

The Centre is committed to pursuing a programme of knowledge exchange that makes a positive impact, including fostering dialogue between policy makers, practitioners and academia.

Dr Sharon Vincent was Research Fellow at the Centre between 2007 and 2012.

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The Centre was previously known as The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP). This name features of publications produced between 2007-2011.

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[i] Vincent (2010) Learning from Child Deaths and Serious Abuse, Edinburgh, Dunedin.
[ii] Vincent 2010 ibid; Injury Prevention February 2011 Vol 17, Supplement 1.
[iii] Cumulative Harm: A conceptual overview (2007) Victorian Government Department of Human Services.
[iv] These resources are available on the NSW Department of Community Services website.
[v] Newton, R; Frederick, J; Wilson, E. et al. (2010) Legislation and Child Death Review Processes in Australia: Understanding Our Failure to Prevent Child Death, UNSW Law Journal Volume 33(3), 987-1012.